HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	HB 5301	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health Care Appropriations Subcommittee and Hudson	73 **Y's**	36 **N's**
COMPANION BILLS:	None	**GOVERNOR'S ACTION:**	Pending

SUMMARY ANALYSIS

HB 5301 passed the House and the Senate on March 9, 2012. The bill:

- Removes a prohibition preventing children who are eligible for coverage under a state health benefit plan from being eligible for services provided through the Kidcare program.
- Authorizes the development of a new system of eligibility determination for Medicaid and the Children's Health Insurance Program (CHIP), subject to appropriation; setting an implementation date; and establishing an executive management team.
- Limits payment for emergency room services for non-pregnant Medicaid recipients 21 years of age or older to 6 visits per fiscal year.
- Authorizes the agency to seek approval to adjust hospital inpatient rates due to insufficient intergovernmental transfers; extending the statutory deadline for hospital rate adjustments to October 31; extending the statutory deadline for the reconciliation of errors in hospital cost reporting and rate calculations to October 31.
- Defines the components of the plan to convert hospital inpatients rates to a diagnosis-related group (DRG) payment system and establishing a timeline for full implementation by July 1, 2013.
- Continues the years of audited data used in determining Medicaid and charity care days for hospitals participating in the Disproportionate Share Hospital (DSH) Program; continuing disproportionate share payments for any non-state government owned or operated hospital eligible for payment on July 1, 2011 for Fiscal Year 2012-2013; removing the specific fiscal year reference from statutes resulting in recurring authorization to distribute moneys under the statutorily defined teaching hospital program; and allowing accredited osteopathic hospitals to participate in the distribution of funds to statutory teaching hospitals.
- Repeals statutory authority relating to the regional perinatal intensive care centers program and the primary care disproportionate share program.
- Authorizes the statewide enrollment of Medicaid recipients diagnosed with HIV/AIDS into a managed care plan that specializes in providing health care services through a teaching and research-oriented organization.
- Revises the methodology for determining a county's eligible recipients for the purpose of county contributions to Medicaid; revises the methodology of collecting those funds; establishes the guidelines to request refunds; and authorizes the transfer of funds from General Revenue to the Lawton Chiles Endowment Fund.
- Deletes references to the Adult Day Health Care Waiver program in provisions relating to Medicaid eligibility and in provisions relating to duties and responsibilities of the Department of Elderly Affairs.
- Authorizes the expansion of the home health agency monitoring pilot project in Miami-Dade County on a statewide basis, except in counties in which the program will not be cost-effective to administer.
- Authorizes the expansion of the comprehensive care management pilot project for home health services on a statewide basis and expand the scope of services to include private duty nursing and personal care services, except in counties in which the program will not be cost-effective to administer.
- Authorizes Program of All-inclusive Care for the Elderly (PACE) sites in Broward County and in Manatee, Sarasota, and DeSoto counties; and approves up to 150 initial enrollees for each site, subject to a specific appropriation.
- Allows a public hospital located in trauma service area 2 which has local funds available for intergovernmental transfers to have its reimbursement rates adjusted for Fiscal Year 2011-2012 only.

The General Appropriations Act (GAA) appropriates $7.02 million and includes $62.98 million in cost savings measures as a result of the funding decisions for the Medicaid program.

This bill has an effective date of July 1, 2012, except as otherwise expressly provided in the act.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Florida Kidcare Program

The Kidcare program was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997, later known more simply as the Children's Health Insurance Program (CHIP). The federal authority for the CHIP is located in Title XXI of the Social Security Act.[1] Initially authorized for 10 years, and then recently re-authorized[2] through 2019 with federal funding through 2015, the CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for Kidcare is found in part II of chapter 409, F.S.

Kidcare encompasses four programs: Medicaid for children, the Medikids program, the Children's Medical Services Network, and the Florida Healthy Kids program. Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act. Families also contribute to the cost of the coverage under the Title XXI-funded components of Kidcare based on their household size, income, and other eligibility factors. For families with incomes above the income limits for premium assistance or who do not otherwise qualify for assistance, Kidcare also offers an option under the Healthy Kids component and the Medikids component for the family to obtain coverage for their children by paying the full premium.

Eligibility for the Kidcare components that are funded by Title XXI is determined in part by age and household income as follows:[3]

- Medicaid for Children: Title XXI funding is available from birth until age 1 for family incomes between 185 percent and 200 percent of the Federal Poverty Level (FPL).
- Medikids: Title XXI funding is available from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL.
- Healthy Kids: Title XXI funding is available from age 5 until age 6 for family incomes between 133 percent and 200 percent of the FPL. For age 6 until age 19, Title XXI funding is available for family incomes between 100 percent and 200 percent of the FPL.
- Children's Medical Services Network: Title XXI and Title XIX funds are available from birth until age 19 for family incomes up to 200 percent of the FPL for children with special health care needs. The Department of Health (DOH) assesses whether children meet the program's clinical requirements.

Kidcare is administered jointly by the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the Department of Health (DOH), and the Florida Healthy Kids Corporation. Each entity has specific duties and responsibilities under Kidcare as detailed in part II of chapter 409, F.S. The DCF determines eligibility for Medicaid, and the Florida Healthy Kids Corporation processes all Kidcare applications and determines eligibility for the CHIP, which includes a Medicaid screening and referral process to the DCF, as appropriate.

To enroll in Kidcare, families utilize a form that is both a Medicaid and CHIP application. Families may apply using the paper application or an online application. Both formats are available in English,

[1] Title XXI – State Children's Health Insurance Program. Found at: http://www.ssa.gov/OP_Home/ssact/title21/2100.htm (Last visited on January 12, 2012.)
[2] Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3. Found at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cogn_public_laws&docid=f:pub1003.111.pdf%20 (last visited on January 12, 2012.)
[3] Florida Kidcare Eligibility. Found at : http://www.doh.state.fl.us/alternatesites/kidcare/images/data/FKC-eligibilityflag-accessible.pdf (Last visited on January 12, 2012.)

Spanish, and Creole. Income eligibility is determined through electronic data matches with available databases or, in cases where income cannot be verified electronically, through submission of current pay stubs, tax returns, or W-2 forms.

The 2011-2012 GAA appropriated $520,962,322 for Kidcare, including $61,436,037 in General Revenue.[4] The Social Services Estimating Conference convened on December 12, 2011, to adopt a caseload and expenditure forecast for Kidcare through June 2015. For the current fiscal year, the program is projected to end the year with a surplus of $39.4 million with $12.8 million of the surplus being General Revenue.[5] For FY 2012-2013, the projected expenditures for General Revenue are $6.2 million below the current year appropriation.

Title XXI of the Social Security Act, as established in the Balanced Budget Act of 1997, excluded from the definition of "targeted low-income child" a "child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State." When Florida enacted Kidcare in 1998, a similar exclusion was included in s. 409.814, F.S. The effect of this exclusion is that children of public employees who would otherwise be eligible for Kidcare have been unable to enroll in Kidcare and receive premium assistance through Title XXI.

In 2010, Congress amended Title XXI of the Social Security Act to provide states the option to receive Federal matching funds for coverage of children of public employees through the CHIP.[6] A state may receive Federal funding to extend CHIP eligibility to otherwise eligible children of public employees in cases where the state has maintained its contribution levels for health coverage for employees with dependent coverage, or can demonstrate that the state employees' health benefits plan's out-of-pocket costs pose a financial hardship for families. The AHCA has indicated that Florida would meet one or both of these conditions.[7]

On April 4, 2011, the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services issued a letter providing guidance on implementation of the new state option for CHIP coverage of children of public employees.[8] The letter addresses how states can demonstrate that they meet either the maintenance of agency contribution condition or the hardship condition. States wishing to elect this coverage option may submit a CHIP State Plan amendment at any time.

This bill removes the exclusion from eligibility for Kidcare of a child who is eligible for coverage under a state health benefit plan on the basis of a family member's employment with a public agency in the state. The effect is that children of these employees would be eligible for subsidized insurance if they meet the general eligibility requirements for Title XXI-funded Kidcare. The bill also moves the requirement for an application for enrollment in the Children's Medical Services Network to include the medical or behavioral health screening from the introductory paragraph of s. 409.814, F.S., to subsection (9), which deals with application requirements.

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[4] See chapter 2011-69, Laws of Florida, Specific Appropriations 146-151.
[5] Social Services Estimating Conferences – Kidcare Program, December 12, 2011. Found at: http://edr.state.fl.us/Content/conferences/kidcare/index.cfm (Last visited January 12, 2012.)
[6] See s. 10203(b)(2)(D) of the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by s. 205 of the Medicare and Medicaid Extenders Act of 2010 (Public Law 111-309).
[7] See Agency for Health Care Administration 2012 Bill Analysis and Economic Impact Statement for SB 510 – on file with the Senate Health Regulation Committee.
[8] Letter to State Health Officials from the Centers for Medicare and Medicaid Services regarding CHIP coverage of children of public employees. Found at: http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009%20schip%20reauth/sho-4-04-11pdf (Last visited on January 12, 2012.)

The FLORIDA System and the Patient Protection and Affordable Care Act (PPACA)

The AHCA is designated as the single state agency authorized to administer the Medicaid program for the state. State law delegates certain functions to other state agencies, including the DCF, the Agency for Persons with Disabilities, and the Department of Elderly Affairs. The DCF is given the responsibility for Medicaid eligibility determinations.

The Florida Medicaid Management Information System (FMMIS) is operated by AHCA and is used to enroll providers, process Medicaid claims, adjudicate claims, accept and process encounter claims for data collection and reimburse providers. The DCF operates the Florida Online Recipients Integrated Data Access (FLORIDA) system to determine eligibility for Medicaid, CHIP, and other public assistance. The FLORIDA System sends data to FMMIS nightly to add and remove individuals based on changes in eligibility.

The FLORIDA System was implemented in 1992. The system was transfer technology from the State of Ohio which was originally designed in the early 1980s. The FLORIDA System was designed to support a service model where face-to-face interviews were conducted at area offices and relies heavily on manual data entry by state employees with no option for direct input by clients. The DCF is facing problems related to the aging of the system including limited availability of hardware and software support; limited pool of trained users; and declining availability of third-party support for new technology and functions.

The DCF has identified risks related to continuing to operate the FLORIDA System without modification including the escalation of system maintenance and modification costs; potential of system failures due to aging infrastructure; and inability to comply with federal law. Since the Medicaid program is a partnership between the state and the Federal government, the program must comply with all Federal requirements, including those outlined in the Patient Protection and Affordable Care Act (PPACA).

The U.S. Congress passed PPACA, and President Barack Obama signed the bill into law on March 23, 2010.[9] Key policy areas of reform include: mandated individual coverage; mandated employer offers of coverage; expansion of Medicaid; individual cost-sharing subsidies and tax penalties for non-compliance; employer tax penalties for non-compliance; health insurance exchanges; expanded regulation of the private insurance market; and revision of the Medicare and Medicaid programs.

On the same day that PPACA was signed into law by the President, Florida's Attorney General filed a federal lawsuit in Pensacola challenging the constitutionality of the new law.[10] On January 31, 2011, the Federal District Court for the Northern District of Florida, Pensacola Division, declared the individual mandate provision of PPACA unconstitutional, and since the law lacks a severability clause, the entire Act was void.[11]

This decision was appealed to the United States Court of Appeals for the Eleventh Circuit. The Eleventh Circuit affirmed the decision that the individual mandate violates the Commerce Clause, but upheld the remaining portions of PPACA.[12] The Supreme Court of the United States has granted review of the case.[13] In addition to reviewing the constitutionality of the individual mandate, the Court will also review whether the changes to the Medicaid program are an unlawful coercion. The Court has scheduled oral arguments on March 26, 27, and 28. The Court will likely render its decision before the end of this year.

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[9] P.L. 111-148, 124 Stat. 119 (2010).
[10] State of Florida v. U.S. Dept. of Health and Human Services, Case No.: 3:10-cv-91-RV/EMT (N.D. Fla.)
[11] *See* Florida v. U.S. Dept. of HHS, Case No. 3:10-cv-91-RV/EMT (N.D. Fla.), *Order and Memorandum Opinion on Defendants' Motion to Dismiss*, October 14, 2010.
[12] State of Florida v. U.S. Dept. of Health and Human Services, 780 F. 3d 1235 (2011).
[13] NFIB v. Sebelius (No. 11-393), HHS v. Florida (No. 11-398), Florida v. HHS (No. 11-400).

If the Medicaid provisions of PPACA are upheld, the state must comply with certain provisions of PPACA or risk the loss of federal funding. Specifically, PPACA requires that as condition of a state's continued participation in the Medicaid program that by January 1, 2014, the state must:[14]

- Maintain a web site that allows individuals to apply for and enroll in Medicaid and CHIP and to apply for cost sharing benefits through a health benefits exchange. The system must allow for the use of electronic signatures.
- Maintain a web site that allows individuals to compare benefits, premiums, and cost-sharing available to the individual under Medicaid, CHIP, and a health benefits exchange.
- Be able to accept application for and enrollment in Medicaid and CHIP from individuals who applied through a health benefits exchange.
- Provide information to individuals about a health benefits exchange, including premium assistance, to individuals who apply for Medicaid or CHIP but are not eligible.
- Utilize a secure electronic interface with a health benefits exchange sufficient to share information sufficient to allow for determination of an individual's eligibility for Medicaid, CHIP, and premium assistance.

To the extent funds are appropriated, the bill directs the DCF to collaborate with the AHCA to develop a system for eligibility determination for Medicaid and the Children's Health Insurance Program (CHIP) that complies with all applicable federal and state laws and requirements. The AHCA must complete a feasibility study of two alternative methods of compliance and submit a system development plan to the Legislative Budget Commission for approval. The system must be completed by October 1, 2013 and be ready for implementation by January 1, 2014.

In addition to timely and accurately enrolling individuals in public assistance programs, the bills directs that the system must provide a single point of access to information that explains benefits, premiums, and cost-sharing available through Medicaid, CHIP, or any state or federal health insurance exchange, prevent eligibility fraud, and provide fiscal analysis of eligibility cost drivers.

The bill requires the following functions for the system:

- Allow completion and submission of an online application for eligibility determination that includes the use of electronic signatures.
- Allow automatic enrollment of qualified individuals in Medicaid, CHIP, or other state or federal exchanges.
- Allow for the determination of Medicaid eligibility that is based on the Modified Adjusted Gross Income.
- Allow determination of specific categories of Medicaid eligibility and interface with the FMMIS to support a determination.
- Produce transaction data, reports, and performance information.

The bill designates the Secretary of the DCF as having overall responsibility for the project. The project will be governed by an executive steering committee that is comprised of: three staff members of the DCF appointed by the DCF Secretary; three staff members of the AHCA, including at least two Medicaid program staff, appointed by the AHCA Secretary; one staff member from the Children's Medical Services within the DOH appointed by the Surgeon General; and a representative from the Florida Healthy Kids Corporation. The executive steering committee shall have the overall responsibility for ensuring that the project meets its primary business objectives. If the executive steering committee determines that the primary business objectives cannot be achieved, it shall recommend suspension or termination of the project to the Governor, President of the Senate, and Speaker of the House of Representatives.

[14]See PPACA at Sec. 2201 and Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010, Proposed Rule, 76 Fed. Reg. 51148-51199 (April 17, 2011).

County Contributions to Medicaid

Chapter 72-225, Laws of Florida, created s. 409.267, F.S., which required county participation in the cost of certain services provided to county residents through Florida's Medicaid program. In 1991, s. 409.267, F.S., was repealed and replaced with s. 409.915, F.S., which provides that the state shall charge counties for certain items of care and service. Counties are required to reimburse the state for:

- 35% of the cost of inpatient hospitalization in excess of 10 days, not to exceed 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program, and for adult lung transplant services; and
- 35% of the cost of nursing home or intermediate facilities in excess of $170 per month, limited to $55 per resident per month, with the exception of skilled nursing care for children under age 21.

Counties are required to set aside funds to pay for their share of the cost of certain Medicaid services based upon statements provided by the AHCA. The AHCA provides counties with a monthly bill listing Medicaid residents for which the county is responsible for paying. Counties review the information to verify the individuals' county of residence and determine whether the bill is accurate. If the county determines that the bill is correct, it remits a payment to the AHCA that is deposited into the General Revenue Fund.

If a county determines that an individual for which it has been billed is not a county resident, the amount of the bill is denied and returned to the AHCA. The AHCA researches each rejected bill and provides additional documentation to the county to support its original determination of residency or identifies another county that should be billed. This process continues until the county pays the bill, another county is billed for the individual in question, or until the AHCA determines that the cost cannot be billed to a specific county. The majority of disputes with the AHCA are over determining the correct county of residence.

As of December 31, 2011, unpaid billings from all counties totaled $325.5 million. This amount includes bills that have been disputed by a county, researched by the AHCA and rebilled, and are awaiting payment by the counties. For the period from state fiscal year 1994-1995 through 2006-2007, county contributions to Medicaid collections totaled approximately 93 percent of total billings in any fiscal year. Each fiscal year since 2007-2008, county contributions to Medicaid collections have dropped to less than 90 percent of total billings, with only 64.7 percent of billings billed in 2010-2011 being paid in that year. The decline in amount of billings collected has resulted in the backlog of past due billings.

The Florida Revenue Sharing Act of 1972 was a major attempt by the Legislature to ensure a minimum level of revenue parity across units of local government.[15] [16] Provisions in the enacting legislation created the Revenue Sharing Trust Fund for Counties. Currently, the Trust Fund receives 2.9 percent of net cigarette tax collections and 2.044 percent of sales and use tax collections.[17] An allocation formula serves as the basis for the distribution of these revenues to each county that meets the strict eligibility requirements. The county revenue sharing program is administered by the Department of Revenue (DOR) and monthly distributions are made to the eligible counties.

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[15] A full description including tables providing estimates of distributions to counties from the county revenue sharing program can be found in the 2011 Local Government Financial Handbook. See Florida Legislature, Office of Economic and Demographic Research, 2011 LOCAL GOVERNMENT FINANCIAL INFORMATION HANDBOOK, available online at http://edr.state.fl.us/Content/local-government/reports/lgfih11.pdf

[16] Chapter 72-360, Laws of Florida.

[17] Sections 212.20(6)(d)4. And 210.20(2)(a), F.S.

There are three categories of shared revenues received by the counties, including the guaranteed entitlement, the second guaranteed entitlement, and a third category which includes an adjustment for growth in revenues. The guaranteed entitlement is equal to the aggregate amount received from the state in Fiscal Year 1971-1972 under then-existing statutory provisions. The second guaranteed entitlement is equal to the aggregate amount received from the state in Fiscal Year 1981-1982 under then-existing statutory provisions minus the guaranteed entitlement. The revenue is adjusted so that all counties receive at least their minimum entitlement, which means the amount of revenue necessary for a county to meet its obligations as a result of pledges, assignments, or trusts entered into which obligated Trust Fund monies. Finally, after making these adjustments, any remaining Trust Fund monies shall be distributed on the basis of additional revenue of each qualified county in proportion to the total additional revenues for qualified counties.

There are no restrictions on the use of these revenues other than a statutory limitation regarding funds that can be used as a pledge for indebtedness. Chapter 218.25, F.S., restricts the amount of funds that can be pledged for bonded indebtedness. Counties are allowed to pledge the guaranteed entitlement proceeds.[18] Additionally, the second guaranteed entitlement may also be assigned, pledged, or set aside as a trust for the payment of principal or interest on bonds, tax anticipation certificates, or any other form of indebtedness.[19] However, a county may only assign, pledge, or set aside as a trust for the payment of principal or interest on bonds, tax anticipation certificates, or any other form of indebtedness, an amount up to 50 percent of the funds received in the prior year.[20]

Authorized in 1982, the local government half-cent sales tax program generates the largest amount of revenue for local governments among the state-shared revenue sources currently authorized by the Legislature.[21] [22] The program distributes a portion of state sales tax revenue via three separate distributions to eligible county or municipal governments. Additionally, the program distributes a portion of communications services tax revenue to eligible local governments. Allocation formulas serve as the basis for these separate distributions. The program's primary purpose is to provide relief from ad valorem and utility taxes in addition to providing counties and municipalities with revenues for local programs.

The program includes three distributions of state sales tax revenues collected pursuant to chapter 212, F.S. The ordinary distribution to eligible county and municipal governments is possible due to the transfer of 8.814 percent of net sales tax proceeds to the Local Government Half-cent Sales Tax Clearing Trust Fund.[23] The emergency and supplemental distributions are possible due to the transfer of 0.095 percent of net sales tax proceeds to the Trust Fund.[24] The emergency and supplemental distributions are available to select counties that meet certain fiscal-related eligibility requirements or have an inmate population of greater than seven percent of the total county population, respectively.

As of July 1, 2006, the program includes a separate distribution from the Trust Fund to select counties that meet statutory criteria to qualify as a fiscally constrained county.[25] A fiscally constrained county is one that is entirely within a rural area of critical economic concern as designated by the Governor pursuant to s. 288.0656, F.S., or for which the value of one mill of property tax levy will raise no more

[18] Section 218.25(1), F.S.
[19] Section 218.25(2), F.S.
[20] Section 218.25(4), F.S.
[21] A full description including tables providing estimates of distributions to local governments from the half-cent sales tax program can be found in the 2011 Local Government Financial Handbook. See Florida Legislature, Office of Economic and Demographic Research, 2011 LOCAL GOVERNMENT FINANCIAL INFORMATION HANDBOOK, available online at http://edr.state.fl.us/Content/local-government/reports/lgfih11.pdf
[22] Chapter 82-154, Laws of Florida.
[23] Section 212.20(6)(d)2., F.S.
[24] Section 212.20(6)(d)3., F.S
[25] Section 218.67, F.S.

than $5 million in revenue based on the taxable value certified pursuant to s. 1011.62(4)(a)1.a., F.S. This separate distribution is in addition to the qualifying county's ordinary distribution and any emergency or supplemental distribution.

The half-cent sales tax distribution formula is determined annually based on population figures that are established as of April 1 for the state fiscal year beginning July 1. The DOR makes monthly distributions from the Local Government Half-cent Sales Tax Clearing Trust Fund to participating counties.

A county is also authorized to pledge the proceeds for payment of principal and interest on any capital project.[26] For any eligible county receiving a fiscally constrained distribution, the revenues may be used for any public purpose, except to pay debt service on bonds, notes, certificates of participation, or any other forms of indebtedness.[27]

The estimated state revenues shared with counties for Fiscal Year 2011-2012 are:

- Local Government Half-cent Sales Tax – $1,056.6 million
- County Revenue Sharing - $338.8 million

The bill provides for the following changes to county contributions to Medicaid:

- Revises the methodology for determining a county's eligible recipients for the purpose of county contributions to Medicaid. Identification of each county's eligible Medicaid recipients will be based on information in the federally approved Medicaid eligibility system.
- Institutes a payment plan to eliminate the backlog of unpaid billings to Counties.
- Authorizes counties to dispute the total amount of past due billings in an administrative hearing. Counties that do not choose to dispute the total amount will be billed for 85 percent of the total past due amounts.
- Authorizes, beginning in October 2012, the Department of Revenue (DOR) to reduce each county's monthly County Revenue Sharing distribution by 1/36 of the back log amount. Beginning October 2013, DOR will reduce the monthly shared revenue distributions by 1/48 of 2/3 of the backlog amounts. The amount of the reduction cannot exceed 50 percent of the monthly distribution, and must leave sufficient revenue to service outstanding debt.
- Authorizes, beginning in May 2012, the state to reduce the portion of the sales tax it shares with counties through the one-half cent sales tax sharing program for future county billings. The amount of the reduction will be equal to the monthly amount billed by AHCA. The reduction must leave sufficient revenue to service outstanding debt. Counties may request refunds of billed amounts they believe are incorrect.
- Directs AHCA, in consultation with DOR and the Florida Association of Counties, and subject to certain requirements, to develop a process for refund requests from counties.
- Beginning in Fiscal Year 2013-2014 through Fiscal Year 2020-2021, amounts withheld from revenue sharing/half-cent tax distributions will be transferred to the Lawton Chiles Endowment Fund, to the extent that they exceed the official estimate for reimbursements from counties as adopted by the January 12, 2012 Revenue Estimating Conference until $350 million is reached.

[26] Section 218.64(2), F.S.
[27] Section 218.67(5), F.S.

Expand Fraud and Abuse Pilot Projects

Chapter 2009-223, Laws of Florida, establishes two pilot projects relating to home health services to combat an increase in fraud and abuse relating to Medicaid-enrolled home health agencies. Miami-Dade County was designated as the health care fraud area of special concern.

The AHCA was authorized to enter into a contractual arrangement to develop and implement a home health agency monitoring pilot project by January 1, 2010 to verify the utilization and the delivery of home health services and provide an electronic billing interface. The AHCA was also authorized to implement a comprehensive care management pilot project for home health services by January 1, 2010 using face-to-face assessments by a state-licensed nurse, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records.

The AHCA was directed to submit a report evaluating the home health agency monitoring pilot project by February 1, 2011. The initial evaluation of the pilot project indicates that Medicaid expenditures for home health visits in Miami-Dade County and statewide have decreased due to onsite reviews of home health agencies and strict enforcement of prior authorization requirements. Medicaid expenditures for home health visits in Miami-Dade County have decreased by over 35 percent since 2006-2007.

The vendor for the comprehensive care management pilot project has the responsibility of identifying potential problem areas through data analysis and monitoring of selected cases, verifying through medical record review the existence of problems or violations of provider obligations, and reporting findings to the provider and the AHCA. The vendor has completed 3,450 recipient face-to-face assessments, made 116 recommendations for termination of services, and made 114 recommendations for reduction in services.

Since the implementation of these two pilot projects in July 2010, the AHCA has terminated two large home health providers (each serving over 250 Medicaid recipients with annual reimbursement exceeding $1 million) from participation in the Medicaid program and suspended another provider. The number of Medicaid recipients receiving home health visits and the number of home health agencies in Miami-Dade County have also declined. Medicaid expenditures for home health visits in Miami-Dade County for Fiscal Year 2010-2011 are approximately 50 percent lower than the Medicaid expenditures incurred for Fiscal Year 2009-2010.

This bill expands the scope of the two pilot projects to include additional services and counties, effective July 1, 2012. The pilot project to monitor home health services in Miami-Dade County is expanded statewide, except in counties in which the program will not be cost-effective, as determined by the agency. The comprehensive care management pilot project for home health services is expanded to include private duty nursing and personal care services on a statewide basis, except in counties in which the program will not be cost-effective, as determined by the agency.

Florida's Medicaid Hospital Reimbursement Plan

Florida pays hospitals for Medicaid services using cost-based reimbursement methodologies, one for inpatient rates and one for outpatient rates. The methodologies are approved by the federal Centers for Medicare & Medicaid Services (CMS) and documented in official state Medicaid Hospital Reimbursement Plans. The plans are amended as necessary to follow policy and budgetary guidance passed by the Florida Legislature.

In 1990, Florida began placing recurring "reimbursement ceilings" on the growth allowed for hospital per diems. For that year, the ceiling was set at 3.3 percent, meaning that a hospital's per diem was allowed to increase by no more than 3.3 percent of the previous year's rate, regardless of the increase called

for by the cost-based methodology. In subsequent years, the ceiling has been set each year based on a formula using inflation factors.

The state began applying reimbursement ceilings effective July 1990, but certain hospitals are exempt from the ceilings, which means yearly increases in their rates are not limited by the full application of the reimbursement ceilings. A rate that is exempt from the ceilings is commonly called the "exempt rate." All hospitals that are defined as rural hospitals were exempted on an ongoing basis at the outset. Over the years, other hospitals have been made exempt from reimbursement ceilings:

- In 1991, hospitals whose charity and Medicaid days exceeded 15 percent of their overall days were exempted. (That percentage has been lowered over the years and now stands at 11 percent, which allows more hospitals to qualify for the exemption.)
- In 2000, certain teaching hospitals, children's hospitals, and certain specialized hospitals were made exempt.
- In 2001, trauma centers whose percentage of Medicaid days exceeded 9.6 percent were made exempt. (This percentage has also been reduced and is now 7.3 percent.)
- In 2004 and 2005, certain hospitals with neonatal intensive care units were made exempt.
- In 2008, more hospitals were made exempt, including hospitals experiencing an increase in Medicaid caseload by more than 25 percent in any year and hospitals whose Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for the year.

Currently 27 rural hospitals are exempt from the reimbursement ceilings and an additional 68 of Medicaid's 242 hospitals are exempt by virtue of meeting one of the above criteria. Being exempt can significantly increase a hospital's per diem. On the average, a non-rural hospital's exempt rate is about twice as high as what that hospital would be paid without the exemption.

In 2008, the Legislature began passing budget proviso allowing public hospitals that did not qualify for exemptions as described above to provide their own funds or local governmental funds in order to "self-fund" an exemption for the hospital. Such "self-funded" exemptions are not part of the process described above and are handled as stand-alone exemptions for individual hospitals that would not otherwise qualify for exemptions.

Beginning in 2009, non-public hospitals with graduate medical education positions were also allowed to self-fund exemptions from their reimbursement ceilings in this way. For the 2011-12 fiscal year, the GAA contains proviso allowing any hospital to self-fund an exemption from the reimbursement ceilings, up to spending authority of $187 million in intergovernmental transfers (IGTs) and $237 million in federal match, assuming IGTs can be secured to do so.

This bill creates a non-statutory provision of law to authorize, for the 2011-2012 state fiscal year only, the AHCA to adjust the 2011-12 Medicaid reimbursement rates for a public hospital located in the Department of Health's Trauma Service Area 2, if local IGT funds are available to allow for exemptions from inpatient and outpatient limitations, notwithstanding statutory prohibition.

Frequency of Hospital Rate-setting

In 2011, the Legislature directed the AHCA to move to an annual rate-setting cycle for hospitals, effective July 2011. The prior standard had been twice annually – once in July and once in January, resulting in two "rate semesters" per year. In addition, the AHCA was directed in 2011 to establish a deadline of September 30 beyond which hospital rates could not be adjusted until the next fiscal year. The deadline requires that the AHCA must execute letters of agreement (LOAs), or promissory notes, for hospital-related IGTs no later than September 30 for any state fiscal year in order for the IGTs to be effective during that fiscal year.

This bill authorizes the AHCA to submit a 14-day budget amendment in accordance to the provisions of chapter 216, F.S., to request the approval to adjust hospital rates due to insufficient commitments or collections of IGTs. The bill further directs that notwithstanding the $1 million limitation on increases to an approved operating budget contained in ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177. The bill also extends the statutory deadline for rate adjustments from September 30 to October 31 and extends the statutory deadline for the reconciliation of errors in cost reporting and rate calculations from September 30 to October 31.

Diagnosis Related Group (DRG) System for Hospital Reimbursement

DRG is a type of prospective payment system for reimbursing hospital inpatient services that provides an alternative to cost-based per diem reimbursement. DRGs classify an inpatient stay into a group based on the patient's diagnoses, sex, age, and other factors which can include costs of labor, hospital case mix, and overall wellness or acuity of the population. When demographics and external factors that affect cost are considered, groups of related diagnoses are designed to provide a stable and fairly predictable indication of the resources needed for treating a particular patient. This type of system is used in Medicare and seeks to tailor reimbursement more closely to actual costs of treatment for each individual patient.

The bill revises the AHCA's time frames for developing a plan to transition the state's cost-based reimbursement system for hospital inpatient fees to a DRG system. The plan must provide detailed definitions, descriptions, and payment estimates. The AHCA is required to engage an experienced consultant to develop the plan and to report to the LBC on the development of the plan under certain conditions.

Medicaid Managed Care Alternatives

Florida Medicaid costs have increased significantly since its inception, due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. Current estimates indicate that the program will cost $21.4 billion in FY 2012-2013. Florida has made numerous and repeated efforts to control costs in the program through rate reductions, utilization limits, fraud and abuse efforts, and other cost control initiatives. Florida, like other states, turned to managed care for improving access to care, containing costs, and enhancing quality.

This bill authorizes the AHCA, on a statewide basis, to assign Medicaid recipients diagnosed with HIV/AIDS into a managed care plan which offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS.

Medicaid Services

Current law allows Medicaid reimbursement for medical assistance and related services for recipients deemed eligible subject to income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible recipients is subject to the availability of moneys and any limitations established by the GAA or chapter 216, F.S.

States can choose to limit the amount, duration and scope of mandatory and optional services for non-pregnant adults, and may amend the state plan (upon federal approval) to modify coverage of these services at any time. However, states must provide services at a level sufficient to achieve their purpose. Limits must be sufficient to provide services to a vast majority of recipients.

There is no limit on the number of emergency room visits for which Medicaid will reimburse during a fiscal year. Any person needing emergency medical care or any woman in active labor shall not be denied access to appropriate emergency medical services and care. Emergency services and care means medical screening, examination and evaluation by a physician, or by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists. Current statutory authority authorizes a $15 copayment for the use of a hospital emergency department for non-emergency services. A recently enacted provision in Florida law directs the AHCA to seek federal approval to require Medicaid recipients to pay a $100 copayment for non-emergency services and care furnished in a hospital emergency department.[28] Federal approval is pending. For Fiscal Year 2012-2013, it is estimated that a limitation on reimbursement would impact approximately 8,637 non-pregnant adult Medicaid recipients and decrease the number of emergency room visits by 479,316.

This bill limits reimbursement for emergency room visits for non-pregnant Medicaid recipients 21 years of age or older to six visits per fiscal year.

Disproportionate Share Program (DSH)

Each year the Low-Income Pool Council (formerly Disproportionate Share Council) makes recommendations to the Legislature on the Medicaid Disproportionate Share Hospital Program funding distributions to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. However, the legislature delineates how the funds will be distributed to each eligible facility.

The bill amends several provisions of chapter 409, F.S., to implement the changes in DSH program funding for Fiscal Year 2012-2013. The bill:

- Continues to use the 2004, 2005, and 2006 audited data in calculating disproportionate share payments to hospitals for Fiscal Year 2012-2013;
- Continues disproportionate share payments for any non-state government owned or operated hospital eligible for payment on July 1, 2011 for Fiscal Year 2012-2013;
- Removes the specific fiscal year reference from statutes resulting in recurring authorization to distribute moneys under the statutorily defined teaching hospital program; and
- Allows accredited osteopathic hospitals to participate in the distribution of funds to statutory teaching hospitals.

In addition, the bill repeals statutory authority relating to the regional perinatal intensive care centers program and the primary care disproportionate share program.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model was tested through CMS demonstration projects that began in the mid-1980s.[29] The PACE model was developed to address the needs of long-term care clients, providers, and payors.

For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than receiving services in other more costly long term care settings.

[28] Section 409.9081(1)(c), F.S.

[29] Centers for Medicare and Medicaid Services website: http://www.cms.hhs.gov/PACE/ (last visited on January 17, 2012).

Capitated financing allows providers to deliver all the services that participants need rather than being limited to those services reimbursable under the Medicare and Medicaid fee-for-service systems. [30]

The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the State and the Secretary of the Department of Health and Human Services can enter into program agreements with PACE providers.[31]

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing the PACE services and must:[32]

- Have a governing board that includes community representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have demonstrated fiscal soundness; and
- Have a formal participant bill of rights.

The PACE project is a unique federal/state partnership. The federal government establishes the PACE organization requirements and application process. The state Medicaid agency or other state agency is responsible for oversight of the entire application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with the CMS and the state Medicaid agency.[33]

Florida PACE Project

The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially authorized in chapter 98-327, Laws of Florida, and is codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community based services at a cost less than the cost of nursing home care. The PACE project is administered by DOEA in consultation with AHCA.

Section 3, chapter 2006-25, L.O.F., included proviso language in the 2006-2007 GAA to authorize 150 additional clients for the existing PACE project in Miami-Dade County and funding for the development of PACE projects to serve 200 clients in Martin and St. Lucie counties, and 200 clients in Lee County.

Section 3, chapter 2008-152, L.O.F., included proviso language in the 2008-09 GAA to reallocate 150 unused PACE slots to Miami-Dade, Lee and Pinellas Counties. Each site received 50 slots.

Section 20, chapter 2009-55, L.O.F., directed the AHCA, upon federal approval of an application to be a site for PACE, to contract with one private, not-for-profit hospice organization located in Hillsborough County, which provides comprehensive services, including hospice care for frail and elderly persons. This section also authorized the AHCA, in consultation with DOEA and subject to an appropriation, to approve up to 100 slots for the program.

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[30] *Id.*
[31] *Id.*
[32] PACE Fact Sheet, available at http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf.
[33] *Id*.

Section 14, chapter 2010-156, L.O.F., directed the AHCA to contract with a private health care organization to provide comprehensive services to frail and elderly persons residing in Polk, Highlands, Hardee, and Hillsborough Counties. This section also authorized 150 initial slots for the program.

Section 15, chapter 2010-156, L.O.F., directed AHCA to contract for a new PACE site in Southwest Miami-Dade County and approved 50 initial slots for the program.

Section 17, chapter 2011-61, L.O.F., directed AHCA to contract for a new PACE site in Palm Beach County and authorized up to 150 initial enrollee slots.

In addition to receiving the necessary legislative authority, the development of a new PACE organization or the expansion of an existing program is a lengthy process that includes: identifying a service area, acquiring and renovating a PACE facility and processing the PACE application through the state and the federal review system.

The bill authorizes, subject to an appropriation, up to 150 initial enrollee slots each to two new PACE projects in Broward County and in Manatee, Sarasota, and DeSoto counties.

Medicaid Home and Community Based Services Waiver Program

In 1981, the U.S. Congress approved the use of Medicaid home and community-based-services (HCBS) waiver programs to allow states to provide certain Medicaid services in the home for persons who would otherwise require institutional care in a hospital, nursing facility, or intermediate care facility. These programs are federally-approved Medicaid initiatives authorized by Title XIX of the Social Security Act, Section 1915.

The HCBS waiver programs are initially approved for 3 years and may be renewed at 5-year intervals. If a state terminates an HCBS waiver, federal law requires that recipients receive continued services in an amount that does not violate the comparability of service requirements established in the Social Security Act.[34] In effect, the state has to transition recipients into programs with comparable services. Florida currently operates 15 home and community-based-services waiver programs.[35]

The Adult Day Health Care Waiver program, initially implemented in April 2004, is designed to meet the health and supportive needs of adults with functional and/or cognitive impairments through an individual plan of care implemented at an adult day health care center. This program serves adults who are physically impaired or mentally confused and may require supervision, increased social opportunities, and assistance with personal care or other daily living activities. Adult day health care services allow frail elders to remain in their home or community instead of going to a nursing facility.

The Adult Day Health Care Waiver program is available only to residents of Lee County. Currently, there are approximately 25 recipients enrolled in this waiver program, and it is set to expire in March 2012. It is anticipated that the 25 recipients will choose to transition into either the Nursing Home Diversion Waiver or the Aged and Disabled Adult Waiver programs. Both programs offer comparable services.

[34] 42 C.F.R. 441.356.

[35] Found at: http://www.fdhc.state.fl.us/Medicaid/hcbs_waivers/index.shtml (last visited on January 17, 2012).

The bill modifies statutory authority by deleting references to the Adult Day Health Care Waiver in provisions relating to Medicaid eligibility and duties and responsibilities of the DOEA. The waiver program is scheduled to sunset in Fiscal Year 2011-2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

$143,208,191 million in federal Medicaid funds will be generated through the implementation of the DSH programs. Collection of the back log of county billings for Medicaid is expected to increase general revenue collections by $77,500,000 in Fiscal Year 2012-13.

2. Expenditures:

	FY 2012-13
EXPAND FRAUD PREVENTION PILOT PROJECTS - Contracts	
General Revenue	$ 2,111,202
Medical Care Trust Fund	$ 2,111,202
Total	**$ 4,222,404**
DIAGNOSIS RELATED GROUPS (DRG)	
General Revenue	$ 775,000
Medical Care Trust Fund	$ 1,325,000
Total	**$ 2,100,000**
MEDICAID ELIGIBILITY SYSTEM EVALUATION	
General Revenue	$ 350,000
Medical Care Trust Fund	$ 350,000
Total	**$ 700,000**
BUDGETARY INCREASES	
General Revenue	**$ 3,236,202**
Medical Care Trust Fund	**$ 3,786,202**
Grand Total of Increases	**$ 7,022,404**
LIMIT EMERGENCY ROOM VISITS	
General Revenue	($19,629,652)
Medical Care Trust Fund	($26,977,339)
Refugee Asst Trust Fund	($ 107,913)
Total	**($46,714,904)**
SAVINGS FROM EXPANSION OF HOME HEALTH SERVICES PILOT PROJECTS	
General Revenue	($ 6,054,414)
Medical Care Trust Fund	($ 8,268,852)
Refugee Asst Trust Fund	($ 459)
Total	**($ 14,323,725)**

SUNSET OF ADULT DAY HEALTH CARE WAIVER PROGRAM	
General Revenue	($ 822,937)
Operations & Maintenance Trust Fund	($ 1,123,921)
Total	**($ 1,946,858)**
BUDGETARY DECREASES	
General Revenue	**($ 26,507,003)**
Medical Care Trust Fund	**($ 35,246,191)**
Operations & Maintenance Trust Fund	**($ 1,123,921)**
Refugee Asst Trust Fund	**($ 108,372)**
Grand Total of Decreases	**($ 62,985,487)**
TOTAL BUDGETARY IMPACT	
General Revenue	**($ 23,270,801)**
Medical Care Trust Fund	**($ 31,459,989)**
Operations & Maintenance Trust Fund	**($ 1,123,921)**
Refugee Asst Trust Fund	**($ 108,372)**
Grand Total of All	**($ 55,963,083)**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Local governments and other local political subdivisions may provide $102,612,386 million in contributions for the DSH programs. Collection of the backlog of County billings will increase General Revenue collections by $77,500,000 in Fiscal Year 2012-13.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals providing a disproportionate share of Medicaid or charity care services will receive additional reimbursement towards the cost of providing care to uninsured individuals.

D. FISCAL COMMENTS:

The AHCA will distribute $246,571,577 through the federal Disproportional Share Hospital (DSH) program to hospitals providing a disproportionate share of Medicaid or charity care services.